Chapter 3

SCHOOL HEALTH SERVICES

Consent to Health Services

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School Entrance Physical Examinations

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Consent to Health Services

Consent to medical treatment must be in writing, signed by the person giving consent, and given to the doctor, hospital, or other medical facility that administers the treatment. The consent must include the name of the child, the name of one or both parents, if known, the name of any managing conservator or guardian of the child, the name of the person giving consent and the person's relationship to the child, a statement of the nature of the medical treatment to be given, and the date the treatment is to begin.[1]

When the person having the right to consent cannot be contacted and that person has not given notice that no one else may consent, the following persons may consent to medical, dental, psychological, and surgical treatment of a child:[2]

- Grandparent of the child;
- Adult brother or sister of the child;
- Adult aunt or uncle of the child;
- Educational institution in which the child is enrolled that has received written authorization to consent from a person having the right to consent;
- Adult who has actual care, control, and possession of the child and has written authorization to consent a person having the right to consent;
- Court having jurisdiction over a suit affecting the parent-child relationship of which the child is the subject;
- Adult responsible for the actual care, control, and possession of a child under the jurisdiction of a juvenile court or committed by a juvenile court to the care of an agency of the state or county; or
- Peace officer who has lawfully taken custody of a minor if the peace officer believes the minor is in need of immediate medical treatment.

This does not apply to consent for the immunization of a child. For a description of who may consent to immunization of a child, please see the section of this manual on immunizations.

A child may consent to medical, dental, psychological, and surgical treatment for the child by a licensed physician or dentist if the child:[3]

- Is on active duty with the armed services of the U.S.;
- Is 16 years of age or older and resides apart from the child's parents, managing conservator or guardian, and manages the child's own financial affairs;
- Consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of Health;
- Is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
- Consents to the examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use; or
- Is unmarried, is the parent of a child, and has actual custody of his or her child and consents to medical, dental, psychological, or surgical treatment for the child.

Consent by a child to medical, dental, psychological, or surgical treatment is not subject to disaffirmance because of minority.[4]

No psychological examination, test, or treatment may be administered without the written consent of the child's parent.[5] Prior written consent from a parent must be obtained before a school district or school district employee may refer a student to an outside counselor for care or treatment of a chemical dependency or an emotional or psychological condition. The school district must disclose to the student's parent, managing conservator, or guardian any relationship between the district and the outside counselor, inform the student and the student's parent of any alternative public or private source of care or treatment reasonably available in the area, require the approval of appropriate school district personnel before a student may be referred for treatment or before a referral is suggested as being warranted, and prohibit any disclosure of a student record that violates state or federal law.[6]

A child may consent to counseling for suicide prevention, chemical addiction or dependency, or sexual, physical, or emotional abuse. A licensed or certified physician, psychologist, counselor, or social worker having reasonable grounds to believe that a child has been sexually, physically, or emotionally abused, is contemplating suicide, or is

suffering from a chemical or drug addiction or dependency, may counsel the child without consent of the parents or advise the child's parents, without consent of the child, of the treatment needed by or given to the child.[7]

Access to Student Records

Access by Parents

In the State of Texas, a parent is entitled to access to all written records of a school district concerning the parent's child,[8] including:

- Attendance records;
- Test scores;
- Grades;
- Disciplinary records;
- Counseling records;
- Psychological records;
- Applications for admission;
- Health and immunization information;
- Teacher and counselor evaluations; and
- Reports of behavioral patterns.

"Parent" includes a person standing in parental relation. The term does not include a person as to whom the parent-child relationship has been terminated or a person not entitled to possession of or access to a child under a court order.[9]

A parent is entitled to full information regarding the school activities of a parent's child except when related to child abuse investigations.[10] Additionally, a parent is allowed full access to student medical records maintained by the school district. On request of a student's parent or guardian, the school district shall provide a copy of the student's medical records to the parent or guardian.[11] The district may charge a reasonable fee for providing copies of this material.[12]

Access by Certain School Staff

A school administrator, nurse, or teacher is entitled access to a student's medical records maintained by the school district for reasons determined by school district policy.[13] A

school administrator, nurse, or teacher who views medical records shall maintain the confidentiality of those medical records. This section does not authorize a school administrator, nurse, or teacher to require a student to be tested to determine the student's medical condition or status.

School Entrance Physical Examination Requirements

Requirements For Enrollment

There is no requirement that a child must receive a physical examination upon entrance to school, whether the child is transferring from a different district or entering school for the first time. However, school readiness exams conducted by a primary care provider can help parents determine whether their child is ready to begin school. According to Section 25.002 of the Texas Education Code (TEC), several documents must be furnished to the school within 30 days of a child's entrance, including a birth certificate, previous school records, and immunization records. These documents may be furnished by either a parent, guardian or the child's previous school.[14]

Immunizations

All children must be immunized against diphtheria, rubeola, rubella, mumps, tetanus, and poliomyelitis to comply with Section 38.001 of the TEC.[15] A student may be exempt from immunizations if they submit an affidavit signed by a physician stating that the immunization would be harmful to the health of the child or a member of the child's household. If a student's parent/guardian presents a signed affidavit stating that the immunization conflicts with the family's religion, the student may also be exempt from this requirement. The family must be a documented member of the religious organization. This exception is nullified in the case of an epidemic or emergency declared by the commissioner of public health. Provisional enrollment may be granted by the school provided the child has begun the series of required immunizations and continues to receive them as soon as medically possible.

Further information about immunizations can be found in Chapter 4, *Immunizations*, of this manual. For more complete legal citations refer to Appendix A of this manual.

Population-Based Screening Programs: State Mandated

An individual is exempt from screening if screening conflicts with the tenets and practices of a recognized church or religious denomination of which the individual is an adherent or a member. To qualify for the exemption, the individual or, if the individual is a minor, the individual's parent, managing conservator, or guardian must submit to the chief administrator of the school on or before the day of the screening procedure an affidavit stating the objections to the screening. The chief administrator of each school shall ensure that each individual admitted to the school complies with the screening requirements or submits an affidavit of exemption.[16] For more complete legal citations refer to Appendix A of this manual.

Annual Report

Annual reports of all school-related screening activities must be submitted to the Texas Department of Health by June 30 of each year.[17] Reports of students failing screenings shall be submitted to TDH upon request.

Vision and Hearing Screening[18]

The Special Senses and Communication Disorders Act, Section 36.001, Health and Safety Code,[19] requires that all children enrolled for the first time in any public, private, parochial, or denominational school, in a Texas Department of Protective and Regulatory Services child-care center or licensed day care home in Texas, or who meet certain grade criteria (specified below), must be screened or have a professional examination for possible vision and hearing problems. Evidence of screening conducted within one year prior to enrollment may also fulfill this requirement. The screening must be performed by a licensed physician, another licensed professional qualified to evaluate vision or hearing, or a Texas Department of Health-certified screener trained for vision or hearing screening. The requirements for vision and hearing screening apply each year for children enrolled in any licensed child-care center or licensed group day care home or school program at the ages or grades listed below:

WHO MUST BE SCREENED	WHEN SCREENING MUST BE DONE
4-year-olds Kindergartners Any other first-time entrants (4 years* through 12th grade)	Within 120 days of admission -or- Before end of first semester
1st-, 3rd-, 5th-, 7th-, & 9th- grades	Anytime within the school year (preferably within first semester)

*Although not required, licensed child-care centers and licensed group day care homes are encouraged to screen all children younger than 4 years of age who can reliably respond to the screening tests outlined in the Texas Department of Health's vision and hearing screening protocols.

To collect screening information for each child, a facility may use its own screening form or duplicate forms provided by the Texas Department of Health upon request (M-40, M-60). There must be a screening record on file for each child enrolled. The following data must be recorded: child's name, type of screening, date, screener, and screening results.

Annual reports for vision and hearing screening activities should be submitted to the Texas Department of Health on forms M-40 (hearing screening) and M-60 (vision screening) by June 30th of each year. These forms are mailed to schools and child care facilities annually.

Vision Screening Procedures

Vision is most commonly described in terms of an acuity measure, or the best a person can see. 20/20 is considered normal vision, while 20/50 prohibits driving in Texas without special aids. 20/70 is called a visual handicap, and when a person sees 20/200 or worse in his or her better eye with the best possible correction on that eye, that person is considered to be "legally blind."

Approved charts for distance acuity testing include: (1) Snellen Alphabet or Sloan Letter Chart, (2) Snellen "Tumbling E" Chart, and (3) HOTV Matching-Symbol Test.

Relative Sizes of Objects Seen with Specific Acuities are Illustrated by these "E's":

E 20/20 E 20/50 E 20/70 **E** 20/200

Vision can be hampered in a number of ways. When a young child has a refractive error that is different between the right and left eye, the child's brain will ignore the weaker eye and only "see" the image from the stronger eye. As a result the child will not have binocular vision. An adult may see two images, or double vision, but a child who is learning to use vision will begin to see only the better image. This can develop into a condition known as AMBLYOPIA – where both eyes are healthy but the brain uses only the information from the good eye and the other becomes "nonfunctional", commonly known as a "lazy eye." This condition can be corrected with glasses, surgery, and/or patching of the "good eye". If this discrepancy is not corrected by the age of 6 years, the child may have permanent vision loss in the weaker eye.

Strabismus is caused by muscle balance problems, commonly described as "crossed eyes." The imbalance of the muscles causes the eyes to present two different images to the brain. The brain cannot process two different images so only one image from the stronger eye is accepted. Amblyopia can occur from strabismus or from an unbalanced refractive error (as described above). In some cases, glasses or patching may improve the weakened muscle balance, and in other cases surgery will be necessary. When the eyes are able to work together to produce one image, this is called binocular vision. Binocular vision is necessary for depth perception when judging the size and distance of an object. It is an important factor in mobility.

Besides refractive errors and strabismus, injuries and various other physical conditions such as cataracts, glaucoma, and detached retinas can create difficulty in seeing.

Symptoms of vision difficulty may include:

- Appearance: Crossed eyes, red eyes, watery eyes, crusty eyelids, frequent styes, and cloudiness in or around the pupil.

- Behavior: Holds body rigid while looking at distant object, thrusts head forward or backward while looking at distant objects, avoids close work, has short attention span, turns head to use only one eye, tilts head to one side, places head close to book or desk when reading or writing, blinks excessively, rubs eye often, squints, and closes or covers one eye.

- Complaints: Headaches, nausea or dizziness, burning or itching of eyes, has blurry vision when looking up from close work, sees objects double, and undue sensitivity to light.

Treatment for visual problems may include:

- Prescription for glasses or contact lenses;
- Patching eyes and/or exercises;
- Surgery for severe muscle imbalance, cataracts, or severe glaucoma;
- Medication for infections, allergies, glaucoma, and other condition; and
- Educational assistance for the visually impaired and legally blind (this may include visual aids and special classes or schools).

Who Are The Trained Screeners and Specialists?

Trained screeners: In Texas, individuals who screen children for vision problems MUST be certified through TDH unless their professional licenses permit such screening.

Specialists: People who are educated or trained to perform many specialized services for the visually impaired:

- Physician: a medical doctor licensed to practice medicine in the United States.
- Ophthalmologist: a medical doctor trained in diagnosis and treatment of defects and diseases of the eye.
- Optometrist: a professional trained in vision disorders, evaluation for visual aids, and visual habilitation.
- Optician: a professional who grinds lenses, fits them into frames to the wearer's needs.
- Orthoptist: a professional who plans exercise programs for the development or restoration of normal teamwork of the eyes (binocular vision).
- Visual Handicap Educator: an educator who is trained in techniques designed to increase a visually impaired individual's social adaptation skills, including learning and mobility skills.

For more information, please contact:

VISION AND HEARING SCREENING
Bureau of Children's Health
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199
(512) 458 – 7420

Hearing Screening Procedures [2]

The Special Senses and Communication Disorders Act mandates hearing screening in private, parochial, and public schools.

Children entering school for the first time in Texas must be screened for possible hearing problems prior to the completion of the first semester of enrollment or within 120 days of enrollment, whichever is longer, or present evidence of a hearing screening conducted within one year prior to enrollment. Explicit screening requirements and reporting procedures are stated under Special Senses and Communication Disorders Act.[20]

Types of Hearing Losses:

- Conductive: Sound cannot reach the inner ear. Colds and allergies may cause temporary losses of this type.
- Sensori-Neural: This type of defect results from damage to the auditory nerve or brain.
- Mixed: A combination of conductive and sensory factors influence mixed types of hearing losses.

Conditions and Illnesses Affecting Hearing:

- Congenital deafness, sensori-neural, is caused frequently by illnesses in the first trimester of pregnancy (German measles, for example).
- Hereditary deafness is not rare. The cause is unknown.
- Acquired deafness or hearing impairment may be caused by:

1. Toxic agents, such as nicotine, aspirin, streptomycin, neomycin, etc.;
2. Enlarged tonsils and adenoids, sinusitis, allergic rhinitis;
3. Mechanical injury, including skull fracture, sustained environmental noise above 85 dB, or loud impulse noise (rivet gun, air wrench, shotgun, rifle, etc.);
4. Otosclerosis;
5. Psychogenic (hysterical, conversion reaction); or
6. Central deafness, normal sense organ, and auditory nerve with impairment in the brain, i.e., tumors, cerebral hemorrhage.

Methods of Testing

Hearing screening consists of the following three methods of testing:

- Sweep-check: The sweep-check is a rapid screening test designed to identify students needing further examination.
- Puretone-threshold: The puretone-threshold screening test, a more refined exam, is designed to determine the lowest intensity level of hearing acuity in each frequency.
- Impedance: The impedance test measures the transfer of sound energy across the middle ear mechanism. The resulting tympanogram reveals information about the condition of the middle ear. Only audiologists, speech pathologists, and nurses with explicit training in the use of acoustic impedance audiometry should use this method of audiometric screening in the school.

Procedures and Techniques:

- The nurse should test the audiometer accuracy once a month and keep a log of the calibrations.
- Students with draining ears or ear infections should be tested at a later date.
- Students wearing hearing aids should not be administered sweep-check or puretone tests.
- The test location should provide the lowest noise level possible.

- The nurse should familiarize students with the procedure, equipment, sounds, and expectations before testing.
- One-day hearing screening workshops are provided on a statewide basis by personnel from the TDH Vision and Hearing Screening Program or other TDH-approved trainers. These workshops consist of a lecture and practicum training in the use of the audiometer for screening. The practicum and a written test are carried out under the supervision of trained instructors. Guidelines are provided by the TDH Vision and Hearing Screening Program.

TDH Hearing Screening Program

The Texas Department of Health (TDH) provides assistance to hearing screening programs for preschool and school-aged children. Workshops are held around the state to train interested individuals to perform basic hearing screening. There is no charge for training. Please contact your regional coordinator for more information.

Who Are Trained Screeners and Specialists?

Trained Screeners: In Texas, individuals who screen children for hearing problems MUST be certified through TDH unless their professional licenses permit such screening.

Specialists: People who are educated or trained to perform many specialized services for the hearing impaired:

- Physician: a medical doctor licensed to practice medicine in the United States.
- Otologist (also referred to as ear, nose and throat specialist, otolaryngologist, or otorhino-laryngologist): a physician who is a specialist in diseases of the ear and hearing mechanisms and who is licensed to practice medicine in the State of Texas by the Texas Board of Medical Examiners.
- Audiologist: a person who holds a license issued by the State Commission of Examiners for Speech-Language Pathology and Audiology to practice as an audiologist in the State of Texas.
- Speech-Language Pathologist: a person who holds a valid license issued by the State Commission of Examiners for Speech-Language Pathology

and Audiology to practice as a speech-language pathologist in the State of Texas.

- Hearing Aid Dispenser: a person who holds a valid license issued by the Texas Board of Examiners in the Fitting and Dispensing of Hearing Aids to fit and dispense hearing aids in the State of Texas.[21]

To find out more, please contact:
VISION AND HEARING SCREENING
Bureau of Children's Health
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199
(512) 458-7420

Spinal

According to 25 Texas Administrative Code § 37.148[22], all students in grades six and nine (or five and eight), in public and private schools must be screened for abnormal spinal curvature before the end of the school year. If they enter school after the scheduled screening has been performed, they must be screened within 120 days of admission. This requirement may also be fulfilled by screening performed by a professional or by screening that has been performed within the previous year. As with immunizations and vision and hearing screening, parents have the option of substituting a professional examination by a licensed health practitioner in lieu of a school screening. Parents may also seek exemption from spinal screening because of religious conflict but a signed affidavit from the religious organization must be submitted to the school in lieu of screening. The chief administrator of the school is responsible for ensuring compliance of all students, either by actual screening or affidavits of exemption. Registered nurses are not required to be certified by the Texas Department of Health as spinal screeners but are responsible for the planning, implementation, and evaluation of the program.[23]

Students should be screened during their growth spurt, ages 10-14 years (Grades 5-9), to detect spinal deformities early. The screening requirement for children entering grade 6 and 9 may be met if the child was screened for spinal deformities during the previous year.[24]

Who May Screen[25]

Health aides, licensed vocational nurses, physical education teachers, classroom teachers, and volunteers may screen if they participate in a workshop conducted by a Texas Department of Health-approved instructor and have become certified according to the Spinal Screening Program Guidelines. School districts are responsible for maintaining documentation of state certification for the spinal screeners in the district. Each district will need to be able to confirm each spinal screener certification, if an inquiry arises.

Licensed professional health practitioners such as registered nurses, physicians, chiropractors, and physical therapists may screen if their course of study included screening for abnormal spinal curvature or if they received formal advanced instruction as part of their continuing education.

Spinal Screening

Each student must be observed from the front, side, and back:

- While standing straight; and
- While gradually bending forward, with the arms hanging down and palms touching, as if diving into a pool.

The screener observes for head misalignment to one side of the cleft in the buttocks; one shoulder or hip higher than the other; a prominence of the rib cage or the small of the back; unequal distance between arms and body; and a curve in the spine. Students must take off their shoes prior to screening.

Spinal Screening Procedures

Forward Bend Technique: Position I

Student stands facing the screener. He/she should stand straight, feet slightly apart with weight evenly distributed, knees straight, arms at side, and eyes straight ahead.

Observe the following:

- Shoulder
- Waist

- Hip

Is one shoulder higher than the other one? Is the waistline the same on both sides or is there a larger space between the arm and flank on one side? Are the hips level and equal; is one side higher, or does it stand out more than the other?

Forward Bend Technique: Position II

While still facing the screener, the student bends slowly forward until his back is parallel to the floor. The feet are slightly apart, knees straight, the palms of the hands are together and hanging down as if diving into a pool. The head is down and relaxed.

Observe the following:

- Chest Cage Hump
- Lumbar Inequality

Are both sides of the back of the rib cage equal or does the rib cage have a hump on one side?
Are both muscle masses in the small of the back equal or does one stand out more than the other?

Forward Bend Technique: Position III

Student stands as in Position I, with one side toward the screener.

Observe the following:

- Round Back
- Sway Back

Is there an exaggerated roundness in the upper back?
Is there an exaggerated arch in the lower back?

Forward Bend Technique: Position IV

Standing with one side toward the screener, the student bends forward as in Position II.

Observe the following:

- Rib Hump

Is there an accentuated roundness over the rib cage or the area between the lower rib cage and the small of the back?

Forward Bend Technique: Position V

Student has back toward the screener, stands straight as in Position I. Long hair should be pinned up or be evenly separated and brought forward in front of each shoulder. Examiner views the entire back:

Observe the following:

- Head
- Shoulders
- Shoulder Blade (Scapula)
- Spine
- Waist

Does the head line up over the crease in the buttocks or is it displaced to one side? Is one shoulder higher than the other? Is the wing on one shoulder blade higher or does it stand out more than the other one? Is the spine straight or does it curve sideways?

Is the waistline the same on both sides or is there a larger space between the arm and flank on one side?

Forward Bend Technique: Position VI

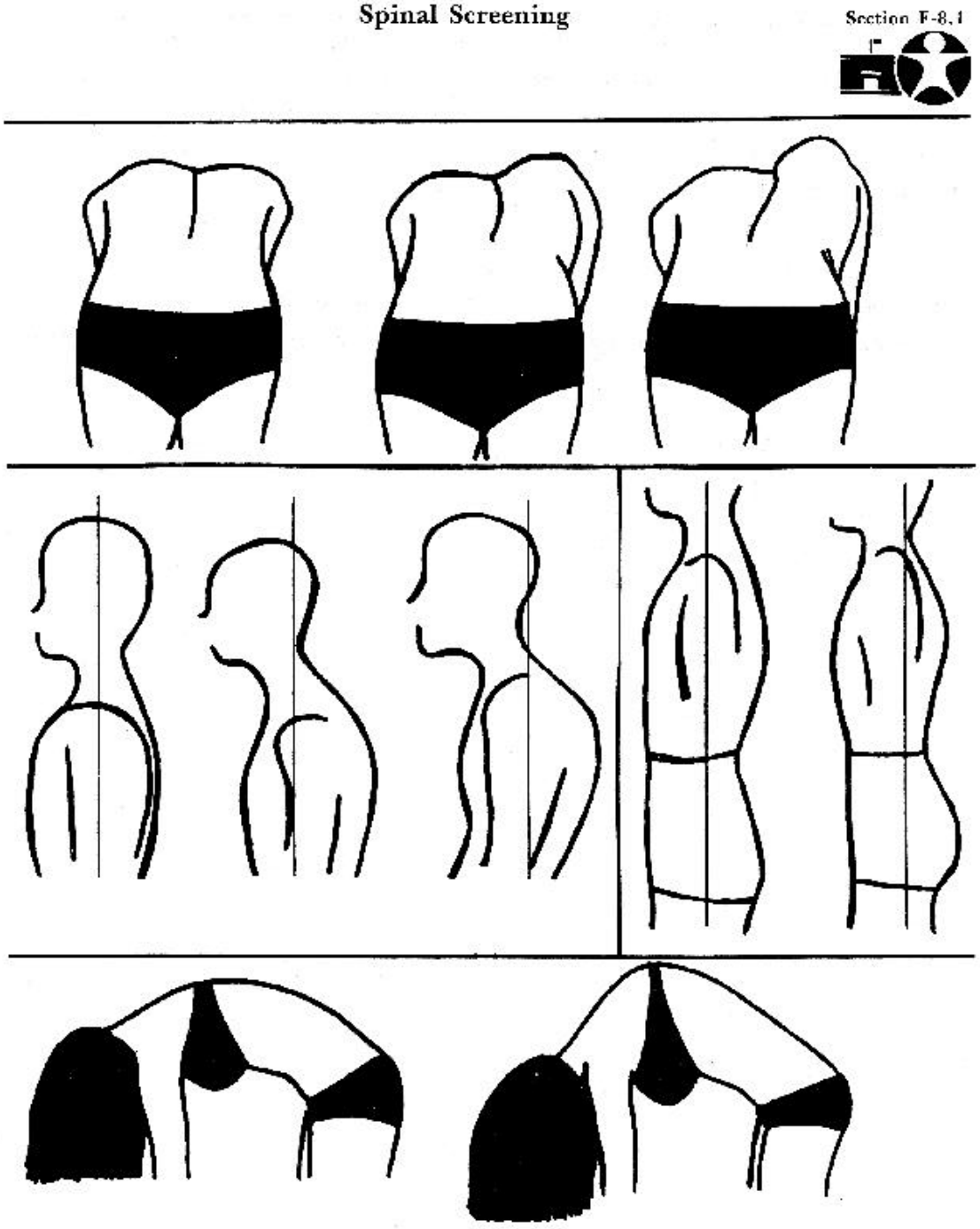
With the back still toward the screener, the student bends forward as in Position II.

Observe the following:

- Is there a bulge on one side of the rib cage?
- Is there a bulge on one side of the lower back?

For information regarding spinal screener training in your area, call the school health specialist at the nearest Regional Education Service Center or contact the Spinal Screening

Program. To order training workshop materials you must be a certified trainer and use the order form. Please allow at least two weeks for materials to be delivered.[26]



Acanthosis Nigricans

Acanthosis nigricans, a hyperkeratinization of the skin, is associated with systemic disorders such as hyperinsulinemia and insulin-resistance and may serve as an indicator for Type 2 diabetes.[27] Insulin-resistance and the compensatory hyperinsulinemia have been linked to obesity, hypertension, hyperlipidemia, stroke, and cardiovascular disease. Ultimately, insulin-resistance results in pancreatic exhaustion, which may lead to the development of Type 2 diabetes.[28]

It is mandated by Texas law (Section 95.001, Health and Safety Code) that those individuals who attend public or private schools located in Texas Education Agency Regional Education Service Centers:1 (Edinburg), 2(Corpus Christi), 3(Victoria), 13(Austin), 15(San Angelo), 18(Midland), 19(El Paso), and 20 (San Antonio) must be screened for acanthosis nigricans.[29] The University of Texas System Texas-Mexico Border Health Coordination Office (TMBHCO)[30] is conducting screenings for acanthosis nigricans in school children throughout nine Texas border counties.

School nurses will conduct the project in schools during state-mandated hearing, vision, and spinal screenings. Acanthosis nigricans is a condition that can be easily evaluated by means of a visual examination. It frequently manifests itself on the nape and sides of the neck, but can also be found on the axillae, elbows, knuckles, knees, and groin area.[31] Hispanics, Native Americans, and African Americans have a higher prevalence of these lesions and could be genetically predisposed and more sensitive to higher insulin levels.[32]

The nurses will record this data on appropriate forms supplied by the TMBHCO. The TMBHCO has the responsibility of interpreting and reporting these measures back to the nurses in an accurate and timely fashion. The nurses will also report any findings and treatments after the child has been seen by a clinician.[33]

A Resource Handbook

The TMBHCO has prepared a resource handbook for those involved in this project. If you would like a copy of this handbook, which includes information about screenings for acanthosis nigricans, obesity, and blood pressure, you may call TMBHCO at 1-956-381-3687 or reach TMBHCO by e-mail at tmbhco@panam.edu.

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Dyslexia[34]

Section 38.003, Education Code,[35] defines dyslexia as a "disorder of constitutional origin manifested by difficulty in learning to read, write, or spell, despite conventional instruction, adequate intelligence, and sociocultural opportunity," and related disorders "similar or related to dyslexia, such as developmental auditory imperception, dysphasia, developmental dysgraphia, and developmental spelling disability."[36]

Students enrolling in public schools in Texas shall be tested for dyslexia and related disorders at appropriate times in accordance with a program approved by the State Board of Education.[37] Each school district must administer at the kindergarten and first and second grade levels a reading instrument adopted by the district to diagnose student reading development and comprehension. The State Board of Education has published "Revised Procedures Concerning Dyslexia and Related Disorders", which can be found at: http://www.tea.state.tx.us/sboe/schedule/9805/dyslexia.html. These guidelines contain characteristics of dyslexia, screening and treatment information and intervention options.

Characteristics of dyslexia include:

- Difficulty reading single words in isolation;
- Difficulty accurately decoding nonsense or unfamiliar words;
- Slow, inaccurate, or labored oral reading; and/or
- Difficulty learning to spell.

Assessment for dyslexia must be done when there is evidence of:

- Poor performance in one or more areas of reading and/or with related areas of writing and spelling that is unexpected for the student's age/grade; and
- Some or all of the characteristics of dyslexia.

The procedure to follow includes:

- Notifying parents or guardians of proposal to assess student for dyslexia;
- Informing parents or guardians of their rights;

- Obtaining parents' permission to assess the student for dyslexia; and
- Administering measures only by professionals who are trained to evaluate students for dyslexia and related disorders.

Depending on the student's age, the following areas should be assessed:

- Reading single words in isolation;
- Word decoding (real and nonwords);
- Phonological awareness;
- Letter knowledge;
- Rapid naming;
- Fluency/rate and accuracy;
- Reading comprehension; and
- Spelling.

If the student is found to have dyslexia, proper instruction should be taken. This is listed in Chapter 5 of *The Dyslexia Handbook* (February 2001).[38] If you have any questions about testing accommodations for students with dyslexia, please call the Student Assessment Division at the Texas Education Association (TEA) at (512) 463-9536. For more general questions about dyslexia, schools can contact the State Dyslexia Hotline at (800) 232-3030 and/or the State Dyslexia Coordinator at (800) 232-3030, extension 1410.

Population-Based Screening Programs: Best Practice

Height and Weight [39]

Growth and development are directly related to inherited characteristics and environmental influences throughout the life cycle. Although growth and development generally follow maturational sequences, culture and the quality of the environment exert significant influences on a person's growth and development. All children should make gains in height and weight more or less regularly from birth to maturity. Seasonal growth and individual differences in body structure as well as hereditary factors must be kept in mind since there is a variation in children of the same age.

The quality of the environment may directly or indirectly influence an individual's growth and development. Physiological needs such as nutrition, sleep, activity, safety, (including protection from elements in the environment such as noise, air and water pollution, crowding, and poor sanitation), and the need for love, all influence growth and development. Culture may influence growth and development through nutrition, physical/social activities, and stress-handling patterns. Height and weight attainment have their origin in the early developmental period but continue to change throughout the years in school.

Because each individual has a unique interaction with members of the culture and selected aspects of the environment, growth and development patterns may or may not fit into the table or graph of "norms" for each age. Each individual's growth and development should be viewed and assessed according to their unique potential relative to cultural and environmental constraints. The significance of changing growth and developmental patterns should be discussed with parents to promote awareness and responsibility for achieving and maintaining optimal health.

Purposes of Growth and Development Screening:

- Identify the student who is not growing and developing normally;
- Stimulate interest in self-responsibility for growth and development;
- Show a relationship between good health practices and growth; and
- Create awareness among school personnel and parents of the importance of good nutrition to growth.

Procedures and Techniques:

- Be sure that scales are in accurate balance.
- Have the student remove shoes, coats, extra sweater, and any heavy objects in pockets.
- Have the student who is not wearing socks place a paper towel on the scale platform before weighing and remove it afterwards.
- Use measuring board for measuring height.
- Record weight to the nearest pound/half-pound; height to the nearest inch/quarter-inch.

- Students with possible abnormal growth patterns should have height, weight, and head circumferences compared to age group norms. Those with a height or weight less than the 3rd percentile or greater than the 97th percentile should be referred to the family physician or a public health clinic.
- A flexible narrow steel tape is recommended for measuring the head circumference. Apply the tape firmly around the student's head above the supraorbital ridges of the most prominent part of the frontal bulge, anteriorly, and over that part of the occiput that gives maximum frontal-occipital circumference.

Follow-Up Procedures:

- Confer with teacher and parents; refer children who are gaining or losing weight excessively to family doctor or public clinic.
- Reweigh students who need follow-up at appropriate intervals.

Suggestions. School nurses may suggest the following for possible incorporation in content areas:

- Health instruction: Before weighing and measuring the students, give instruction explaining normal growth and development.
- Nutrition education: In home economics or health classes in high school and health classes in elementary school, relate nutrition to growth and development.
- Writing: Have students make records at home of their height and weight.
- Mathematics: Have students measure food, especially those weighed in ounces, pounds, and half-pounds, and determine the average weight of boys and girls; graphs and charts may be used.
- Spelling: Have students learn to spell words concerned with height, weight, and measurement.

Blood pressure [40]

Blood pressure measurement should be included in the physical examination as part of the continuing care of the child, not as an isolated screening procedure. Blood pressure

assessment provides a physiological indicator of cardiovascular status. Hypertension (higher than normal blood pressure) in children is defined as persistent blood pressure greater than 95 % of children at the same age and sex on initial screening. The detection of high blood pressure during childhood is of potential value in identifying those children who are at increased risk of primary hypertension (hypertension that develops without apparent cause) as adults and who might benefit from earlier intervention and follow-up care. For many children less than 10 years of age, there is an identifiable cause (secondary hypertension) that can be successfully treated. Older children and adolescents are more likely to have primary hypertension. Early identification of children with elevated blood pressures may make it possible to halt the hypertensive process and the development of complications. Proper diet, regular exercise, and avoidance of smoking are important in helping to maintain normal blood pressure. Children should have their blood pressure evaluated every one to two years.

Trained health care personnel should follow standard practices for procedures for measuring blood pressure. To obtain an accurate measurement the cuff must cover two-thirds of the child's arm. Interpretation of the measurement is made by consulting a table of normative pressures for the child's age. For normal blood pressure readings in children and adolescents consult: Barone, M. (1998).The Harriet Lane Handbook. St. Louis: Mosby. Elevated readings should be confirmed on at least two separate occasions and the average computed.

Oral Health and Dental Screening [41]

Dental screening is an opportunity to detect early dental or oral health problems. Screening is not a replacement for a complete examination in a dentist's office. However, dental screening can be an important component of an oral health program and an important element of a school health program.

The American Academy of Family Physicians (AAFP) and the American Academy of Pediatric Dentistry (AAPD) recommend that infants be scheduled for a first dental visit within six months of the eruption of the first primary tooth but not later than 12 months of age.[42] A school health program should include:

- Dental screening;
- Dental health education; and

- Referrals and follow-up care.

The screening should look for the presence of dental caries (tooth decay), periodontal disease (inflammation of gums and supporting structures), malocclusion (irregularity of the teeth or jaw), and trauma from oral injuries.

School nurses, using a tongue blade and adequate illumination (e.g., penlight) can detect tooth decay and gum problems (e.g., mild gingivitis). However, x-rays are necessary to detect interproximal caries in the early stages.

All children complaining of oral pain, with obvious dental caries, or mild gum disease should be referred to their dentist for a more complete examination. Every attempt should be made by school health personnel to work with parents, encouraging follow-up care with the dentist and getting feedback on any changes that the dentist recommends, in order for school personnel to make the appropriate educational adjustments.

The schools can promote good oral health and prevent oral problems by educating students and parents. Oral health education should focus on:

- Prevention of decay through proper methods of oral hygiene (e.g., brushing, flossing);
- Use of fluoride or fluoridated water;
- Good nutrition including restricting candy and soft drinks; and
- The importance of using mouth-guards in organized high body-contact sports.

In 1973 the National Collegiate Athletic Association required players to wear mouthguards during games. In 1995 the American Dental Association amended its recommendations for oral-facial protection to include all sports participants who were at risk for injury. Currently all states mandate the use of mouthguards during high school football, ice hockey, men's lacrosse, field hockey, and amateur boxing.[43]

EPSDT/Medicaid/Texas Health Steps [44]

The federally mandated Medicaid service, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), known in Texas as Texas Health Steps (THSteps), provides

preventive and therapeutic care for those children ages 0 to 21 years of age who are enrolled in the Texas Medicaid program. To be eligible for THSteps medical check-up services, a client must be under 21 years of age, and be eligible to receive Medicaid.

The overall purpose for medical checkups is to:

- Assess growth;
- Assess development;
- Conduct a complete physical assessment to identify any abnormalities;
- Identify environmental and behavioral risks for disease and injury;
- Provide the child and parent with information for preventing disease and injury; and
- Provide immunizations and anticipatory guidance.

Services

Well Child Physical Exams. These include immunizations, vision screening, hearing screening, laboratory tests, anticipatory guidance, and health education, and follows the American Academy of Pediatrics (AAP) periodicity schedule.

1-2 weeks	13 years
2 months	14 years
4 months	15 years
6 months	16 years
9 months	17 years
12 months	18 years
15 months	19 years
18 months	
2 years	One exam at age
3 years	20.
4 years	
5 years	
6 years	
8 years	
10 years	
11 years	
12 years	

During adolescence every other year is devoted to a prevention visit at 11, 13, 15, 17, 19 years.[45]

Dental Exam. Every six months beginning at one year of age.

Medical Transportation (MTP). Provides free transportation for those who qualify for Texas Health Steps and other Medicaid patients to receive medical, dental, and pharmacy services. The following provisions determine eligibility:

- People, regardless of age, who receive Medicaid and have no other way to get to their health care appointment are eligible for MTP services.
- For MTP staff to determine whether Medicaid will cover a medical service that is requested by a client, and whether it is medically necessary, a client's doctor or dentist may need to complete a form that describes the medical need for the service.
- MTP uses the information on the form to determine whether the provider's location is "reasonably close," meaning that it is in the same county where the client lives, or any adjacent county.
- For travel to or from outside those "reasonably close" counties, the client should call MTP at least five workdays before the medical or dental appointment.

To find more information on THSteps, please contact: 1-877-847-8377.

Speech and Language

Communication has many components. All serve to increase the way people learn about the world around them, utilize knowledge and skills, and interact with colleagues, family, and friends. The development of spoken/oral language normally occurs without formal teaching. It develops as a result of exposure to spoken language. Problems with language development may not be recognized for a long time unless the child simply fails to begin talking. Oral language is the basis for learning reading and written language and for benefiting from instruction in other areas. It is important to identify children whose language is not developing normally so that more specific stimulation and actual intervention can begin as early as possible.

Definition of Speech and Language Disorders[46]

Speech and language disorders refer to problems in communication and related areas, such as oral motor function. These delays and disorders range from simple sound substitutions to the inability to understand or use language or use the oral-motor mechanism for functional speech and feeding. Some causes of speech and language disorders include hearing loss, neurological disorders, brain injury, mental retardation, drug abuse, physical impairments such as cleft lip or palate, and vocal abuse or misuse. Frequently, however, the cause is unknown.

Incidence

More than one million of the students served in the public schools' special education programs in the 1997-98 school year were categorized as having a speech or language impairment. This estimate does not include children who have speech/language problems secondary to other conditions such as deafness. Language disorders may be related to other disabilities such as mental retardation, autism, or cerebral palsy. It is estimated that communication disorders (including speech, language, and hearing disorders) affect one of every 10 people in the United States.

Characteristics

A child's communication is considered delayed when the child is noticeably behind his or her peers in the acquisition of speech and/or language skills. Sometimes a child will have greater receptive (understanding) than expressive (speaking) language skills, but this is not always the case. Speech disorders refer to difficulties producing speech sounds or problems with voice quality. They might be characterized by an interruption in the flow or rhythm of speech, such as stuttering, which is called dysfluency. Speech disorders may be problems with the way sounds are formed, called articulation or phonological disorders, or they may be difficulties with the pitch, volume, or quality of the voice. There may be a combination of several problems. People with speech disorders have trouble using some speech sounds, which can also be a symptom of a delay. They may say "see" when they mean "ski" or they may have trouble using other sounds like "l" or "r". Listeners may have trouble understanding someone with a speech disorder. People with voice disorders may have trouble communicating because of the way their voices sound.

A language disorder is an impairment in the ability to understand and/or use words in context, both verbally and nonverbally. Some characteristics of language disorders

include improper use of words and their meanings, inability to express ideas, inappropriate grammatical patterns, reduced vocabulary, and inability to follow directions. One or a combination of these characteristics may occur in children who are affected by language learning disabilities or developmental language delay. Children may hear or see a word but not be able to understand its meaning. They may have trouble getting others to understand what they are trying to communicate.

Educational Implications

Because all communication disorders carry the potential to isolate individuals from their social and educational surroundings, it is essential to find appropriate, timely intervention. While many speech and language patterns can be called "baby talk" and are part of a young child's normal development, they can become problems if they are not outgrown as expected. In this way an initial delay in speech and language or an initial speech pattern can become a disorder that can cause difficulties in learning. Because of the way the brain develops, it is easier to learn language and communication skills before the age of 5 years. When children have muscular disorders, hearing problems, or developmental delays, their acquisition of speech, language, and related skills is often affected.

Speech-language pathologists assist children who have communication disorders in various ways. They provide individual therapy for the child, consult with the child's teacher about the most effective ways to facilitate the child's communication in the class setting, and work closely with the family to develop goals and techniques for effective therapy in class and at home. Technology can help children whose physical conditions make communication difficult. The use of electronic communication systems allow nonspeaking people and people with severe physical disabilities to engage in the give and take of shared thought.

Vocabulary and concept growth continues during the years children are in school. As children learn increasingly complex reading and writing skills, they increase their understanding and use of language. Speech and/or language therapy may continue throughout a student's school years either in the form of direct therapy or on a consultant basis. The speech-language pathologist may assist vocational teachers and counselors in establishing communication goals related to the work experiences of students and suggest

strategies that are effective for the important transition from school to employment and adult life.

Language problems, like other learning disabilities, are called by several different names including: delayed language, language disorder, language disability, specific language disability, etc. Some people distinguish between children who appear to be developing all aspects of language at a slower rate (delayed language) and those who do not appear to be developing language in the expected way or have uneven language development (language disability). Regardless of the label, language problems should be assessed. A language evaluation must include a hearing test since hearing loss is one reason for delayed language acquisition. Speech-language pathologists typically do the testing for spoken language disabilities. When children are of school age, the evaluation must include the language of instruction and reading and written language.

Like other types of learning disabilities, language disabilities differ in type and severity. Even mild problems in spoken language can have an impact on learning in school. A child should enter first grade with the majority of the language needed for learning. Problems in understanding language will affect almost every aspect of school: following directions, learning vocabulary, understanding instruction, reading comprehension, etc. Problems in using language are often seen in children who do not understand. Some children understand spoken language but have difficulty expressing themselves. A common problem seen in expressive language is difficulty recalling words they know (word retrieval problems). These children understand the word, know it when they hear it, but cannot always call it up when they need it. These children may say, "you know that thing you sweep the floor with"; "I know it, but I can't think of the word"; "Umm,umm, I forget"; etc. Retrieval problems can make children unwilling to participate in class because they interfere with a child's demonstration of what he/she has learned. For example, children may have learned color or letter names, but are unable to give the names when asked. These children can point to the color or letter when the name is said to them.

Some children have difficulty with spoken grammar. They omit words or word endings or get words in the wrong order. Some have difficulty putting their ideas into words in an organized way. Problems in pronunciation of words can be the result of mishearing sounds (Starvation Army/Salvation Army), getting sounds in the wrong order

(aminal/animal), or difficulty producing specific sounds (fum/thumb). Problems with the sound system of language have been reported in many children who have difficulty learning to read. While some speech sounds are acquired later than others, children who have many sounds they cannot make and are difficult to understand may have later problems with phonics.

Language activities with young children are fun for them and can stimulate more language. Reading to children and talking about the pictures and the "story" is an important activity. Making certain new vocabulary is used in many ways and in different situations helps children learn new words.

It is important to have children's language evaluated if there is any concern. Too often, parents are told, "he'll outgrow it," or "just wait, she'll talk when she's ready." This is not good advice when the child is not doing what is expected for the child's age. Speech-language pathologists can determine what the problem is, if any, and make recommendations for working with the child. Oral language is important for social development and effective communication, and because it is the foundation for school learning. Problems should not be overlooked or disregarded.

Screening

The purpose of screening in the area of speech and language is to identify students who may have a speech-language deficit. As a result of the screening, students may be referred for a special education eligibility assessment, or the speech-language pathologist may consult with the teacher or parents regarding the student's speech-language skills. Referrals to special education and eligibility for services are topics covered in Chapter 7 of this manual.

Recommendations: Personnel and Procedure

It is usually the teacher that initially identifies a child at risk for speech and language difficulties. The school nurse may also notice a child who is reluctant to speak or has difficulty making their words understood. If the school nurse notices a problem with speech, a consultation with the teacher and/or parents would be appropriate. Then the school nurse will conduct a hearing and vision screening to rule out possible causes related to deficient hearing or vision. If the child passes these screening tests, he or she is then referred to the school counselor for further intervention and referral to a speech

pathologist or diagnostician. Many districts have their own speech pathologists or diagnosticians. In districts without speech personnel, the counselor can arrange referral to outside agencies for evaluation and treatment. Parents must be notified of all referrals and have the right to refuse.[47]

Screening of early childhood and elementary students should be done by a speech-language pathologist or under that person's supervision, and the screening of middle and high school students should be done by the speech-language pathologist, teacher, guidance counselor, or school nurse. If someone other than the speech-language pathologist is to implement speech-language screening at the middle or high school level, in-service training by the speech-language pathologist should be conducted.

Speech/Language Pathology Includes:

- Identification of children with speech or language disorders;
- Diagnosis and appraisal of specific speech or language disorders;
- Referral for medical or other professional attention necessary for the habilitation of speech or language disorders;
- Provisions of speech and language services for the habilitation or prevention of communicative disorders; and
- Counseling and guidance of parents, children, and teachers regarding speech and language disorders.

Referral and Follow-Up Process

Documentation of testing of children unable to successfully complete the speech and language screenings according to the established criteria should be forwarded to the director of special education or the director's designee.

Screening Instruments

There are a number of commercially available screening instruments. Sample informal screening tools are included on the following pages. Regardless of the instruments used, local norms should be established to determine the validity of the screening instrument for that population.

Sample Forms

Sample speech-language screening forms noted below are provided at the end of this chapter.

- Speech-Language Kindergarten Screening.
- Speech-Language Screening: Grades 1-5.
- Speech-Language Screening Checklist: Grades 6-12.

Fine and Gross Motor Screening [48]

Basic gross and fine motor screening is crucial in determining if the student is developing within the "normal range." The five areas that need to be screened to ensure normal development include balance, bilateral coordination, upper extremity coordination, visual motor control, and upper extremity speed and dexterity. Fine and gross motor skills are essential building blocks to educational success.

The screening allows parents and administrators to be notified when any student shows signs of a significant impairment that should be followed up by a physician. It also gives information to teachers and parents regarding delays in development of gross and fine motor skills of the child.

The Following Materials are Used for the K-3 Screening:

- Playground ball (8 ½ inches).
- Pegboard.
- Playground ball (4 to 5 inches).
- Piece of paper with a circle.
- Piece of paper with a curved path that is 3/4 –inch wide.
- Ten small pegs.
- Stopwatch.

The criteria for failing the fine and gross motor screening is that the student must fail two out of the three gross motor sections (the first three listed below) and both of the fine motor skills (the last two listed below). The evaluation sheet should have two sections: one for comments and one for pass/fail. The student is allowed two attempts to pass each skill.

The Five Areas that Need to be Screened to Evaluate Normal Development Include:

Balance

- Kindergarten: To pass, the child must be able to hold the right foot off the ground for 5 seconds, place it down, and hold the left foot off the ground for 5 seconds.
- Grades 1 and 2: To pass, the child must hold the right foot off the ground for 10 seconds, placed it down, and hold the left foot off the ground for 10 seconds.
- Grade 3: To pass, the child must hold the right foot off the ground for 12 seconds, place it down, and hold the left foot off the ground for 12 seconds.

Bilateral Coordination

- Kindergarten, Grades 1 and 2: To pass, the student must be able to jump in the air and clap their hands while airborne five times consecutively.
- Grade 3: To pass, the child must be able to jump in the air and touch both heels with both hands during two out of three trials.

Upper Extremity Coordination

- Kindergarten: To pass, the child must toss an 8 1/2 –inch playground ball in the air and catch it five consecutive times. The ball must leave the hands and may be trapped in the body.
- Grades 2 and 3: To pass, the child must toss a 4- to 5-inch ball into the air and catch it with hands, five times consecutively, with their hands only. (Examiners should note if the ball does not go above the child's head, if the child stays stationary to catch the ball, and/or if the ball is tossed straight in the air.)

Visual Motor Skills

- Kindergarten: To pass, the child must copy a circle and make predominantly circular lines.
- Grades 1,2, and 3: To pass, the child must draw a line within a curved path without making more than two deviations from the curved line.

(Examiners should note if the child is unable to grasp a pencil properly, does not rotate the paper, and/or if the pencil stays on the paper while the child is duplicating the circle or the path.)

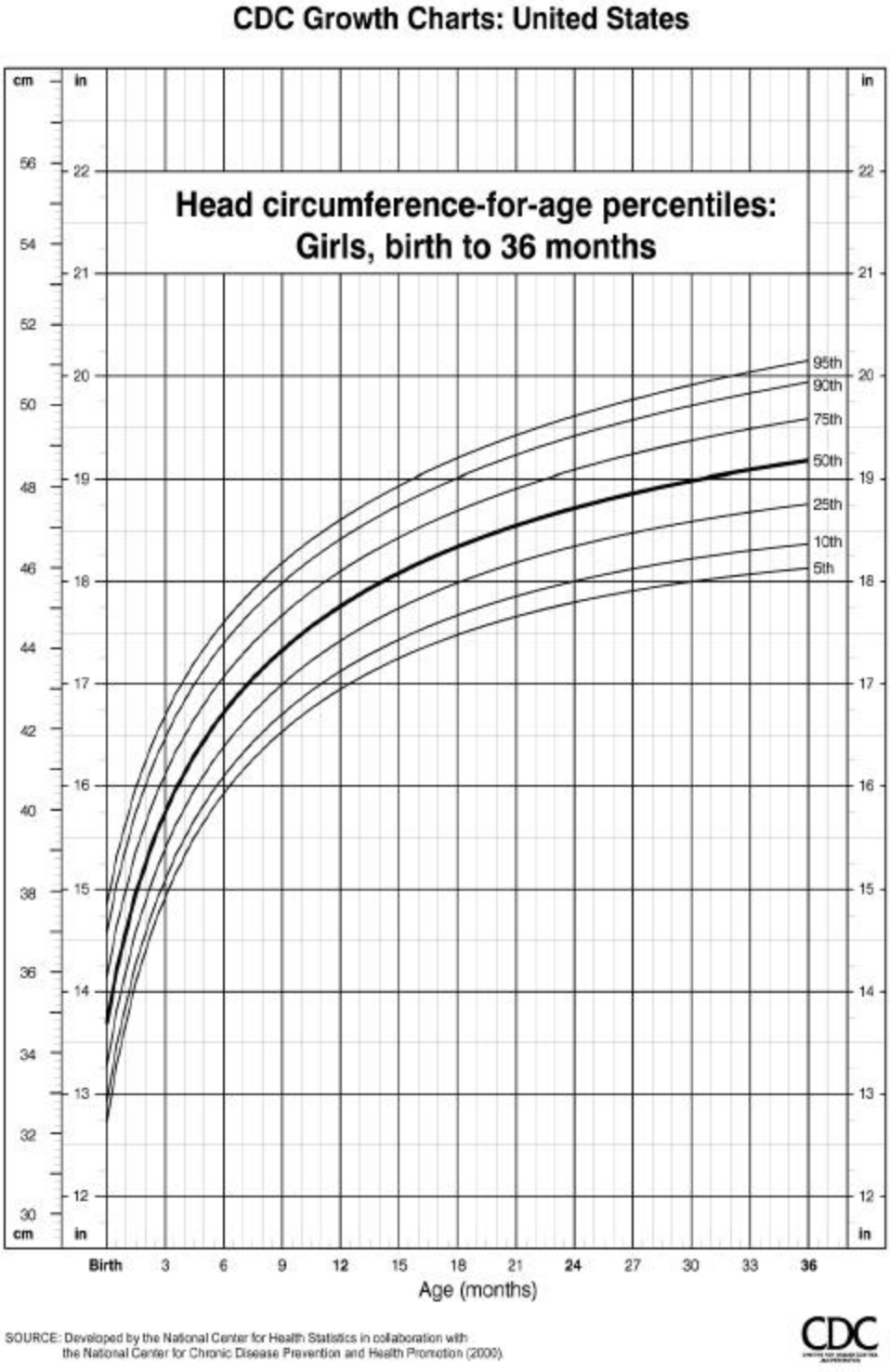
Upper Extremity Speed and Dexterity

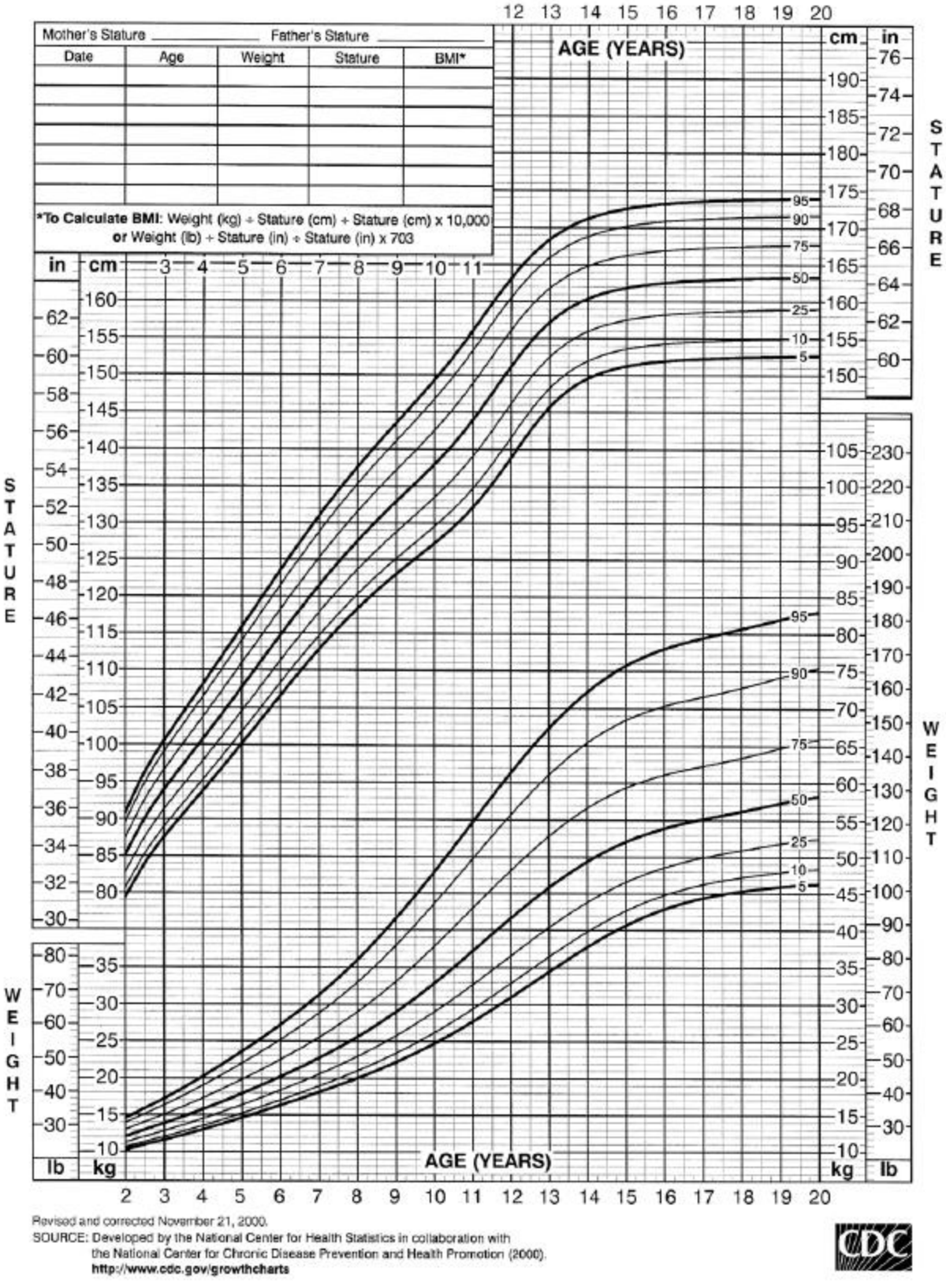
- Kindergarten: To pass, the child must place five pegs, using one hand, into a pegboard within 30 seconds.
- Grades 1 and 2: To pass, the child must place five pegs, using one hand, into a pegboard within 20 seconds.
- Grade 3: To pass, the child must place five pegs, using one hand, into a pegboard within 15 seconds. (Examiners should note if the child picks/does not pick up the pegs one at a time, drops the pegs, does not stabilize the pegboard with one hand, and/or does not use the proper pincer grasp on the pegs.)

Referral and Follow-Up Process

Examiners should document the results of the child's testing, make a referral when the child is unable to meet the screening guidelines, and place all test results in the child's school record. If the student fails the screening, referral is made to the child's health care provider for recommendations for further evaluation. It is important to document the fact that a student has difficulty in a particular area of the screening or fails the screening. The administration needs to be involved with the parents/guardians in helping the student.

Exhibit 1: Growth Charts can be found at: http://www.cdc.gov/growthcharts




2 to 20 years: Girls
Stature-for-age and Weight-for-age percentiles
NAME
RECORD #
Mother's Stature
Father's Stature
Date
Age
Weight
Stature
BMI*
*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703
AGE (YEARS)
STATURE
WEIGHT
95
90
75
50
25
10
5
Revised and corrected November 21, 2000.
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts
CDC

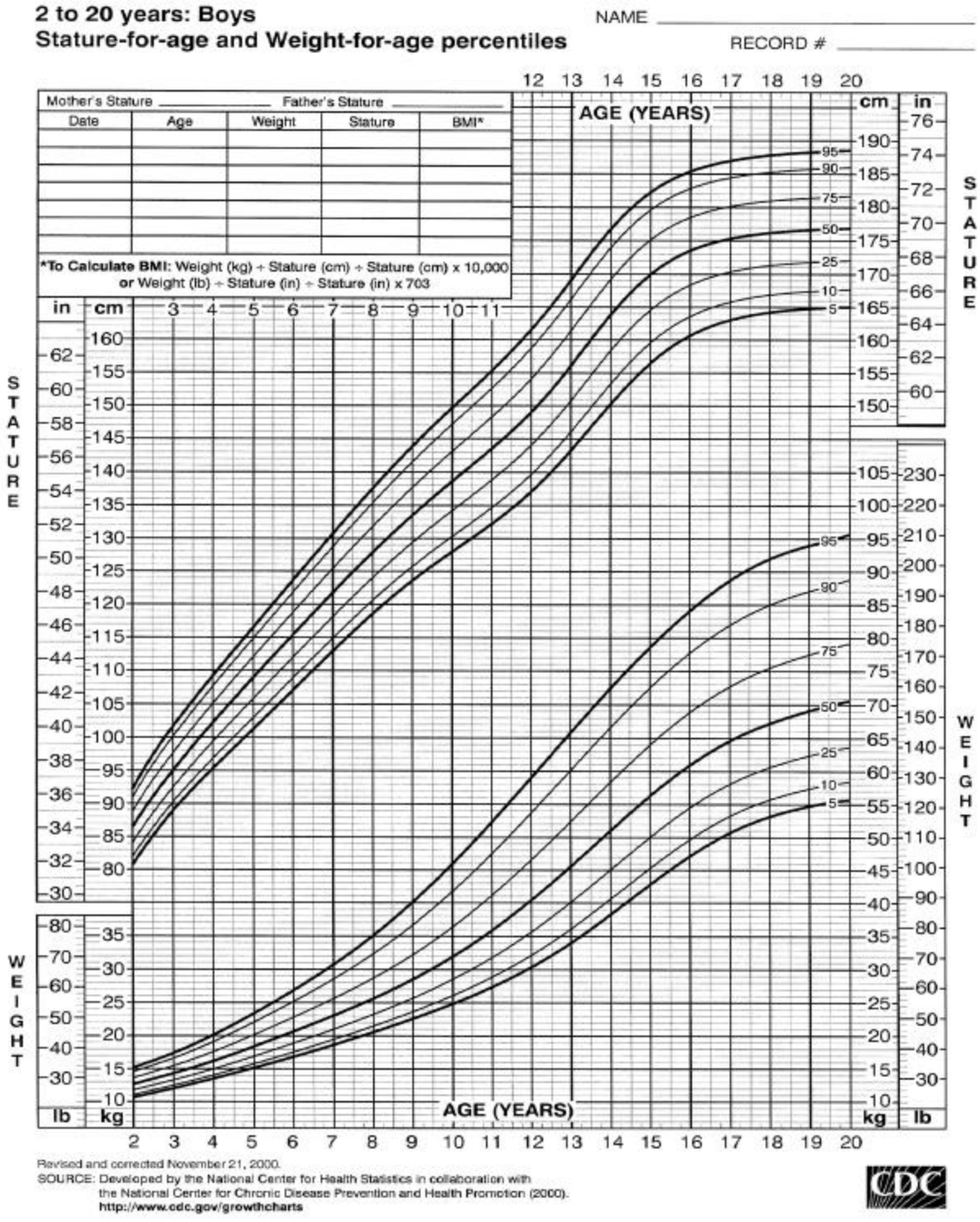

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles
NAME
RECORD #
Mother's Stature
Father's Stature
Date
Age
Weight
Stature
BMI*
*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703
AGE (YEARS)
STATURE
WEIGHT
95
90
75
50
25
10
5
Revised and corrected November 21, 2000.
SOURCE: Developed by the National Center for Health Statistics in collaboration with
the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts
CDC

Exhibit 2: Speech and Language Screening Forms

[SAMPLE]

SPEECH-LANGUAGE KINDERGARTEN SCREENING

Date:_____

NAME: _____ TEACHER: _____ SCHOOL: _____

I. ARTICULATION: Say the following words asking the student to imitate them. Write exactly what the student says.

MOM _____	DAD _____	VALUES _____	ZOOS _____
POP _____	TOOT _____	LITTLE _____	SIS _____
WON _____	GAG _____	JUDGE _____	RARE _____
BIB _____	COKE _____	SHUSH _____	THIRTEEN _____
NINE _____	FIFE _____	CHURCH _____	SPRING _____

II. LANGUAGE

A. Body Parts (Criterion: 5/6)

Show me your:
Head ___ Arm ___ Knee ___ Hand ___ Shoulder ___ Neck ___

B. Opposites (Criterion: 2/3)

Brother is a boy, sister is a _____. A turtle is slow, a rabbit is _____.
The sun shine shines during the day, the moon shines at _____.

C. Distinguishes Prepositions (Criterion 3/4)

Put the block: on the chair _____ under the chair _____
in front of the chair _____ beside the chair _____

D. Verbal Expression and Reasoning (Criterion 3/3)

What do you do when you are tired? _____

What do you do when you are hungry? _____

What do you do when you are cold? _____

E. Function (Criterion 4/5)

What do you do with: a cup _____ scissors _____ a brush _____
a shovel _____ a pencil _____

F. Observations

- Voice Quality --- Comments: _____
- Stuttering --- Comments: _____
- Intelligibility --- Comments: _____

RETURN THIS SCREENING FORM TO: _____

[SAMPLE]

SPEECH-LANGUAGE SCREENING

Grades 1-5

NAME _____ AGE ____ GRADE _____ DATE _____

SCHOOL _____ TEACHER _____ EXAMINER _____

ARTICULATION

Ask the child to repeat the following sentences. Circle the words that the child mispronounced.

1. Today Pete's job was to bake a cake for Kurt.
2. Suzie repaired five television sets.
3. Push the garage door closed.
4. George is watching the magic show.
5. We will ride with Lucy to the yellow house.
6. Nancy found some hangers in my brown bag.

LANGUAGE

For grades 1-5: Engage the student in a conversation and note his use of language, articulation, fluency and voice. Things that you can ask to elicit speech are:

"Why did your family move to _____ ?"

"How is your other school like (different from) this new school?"

"Tell me about your family, hobbies."

LIKENESSES AND DIFFERENCES

For grades 3-5:

For each pair, tell one way they are alike and tell one way they are different:

watch --- clock (L)

bus ----- train (D)

RETURN THIS SCREENING FORM TO: _____

[SAMPLE]

SPEECH-LANGUAGE SCREENING CHECKLIST

Grades 6 - 12

Student's Name _____ Date _____

DOB ___/___/___ Age ____ School _____

Student's Counselor _____ ID# _____

Homeroom Teacher _____ Date Entered School _____

This checklist is to be completed for every student who is new to this school by the student's Language Arts teacher.

This student has been ridiculed by his/her peers for (specify): _____

F=Frequently O=Occassionally N=Not at all N=Not Observed

	F	0	N	N.0.
This student avoids talking in class.				
This student appears frustrated when trying to talk.				
This student avoids talking to peers/adults.				
This student seems concerned about his/her speech.				
This student withdraws from group activities.				
I feel uncomfortable when trying to communicate with this student.				

Academic

This student is experiencing difficulties with:

Listening skills	
Concept work	
Following directions	
Oral reading	
Reading comprehension	
Other (Specify) _____	

OBSERVATIONS

- Voice Quality ---Comments: _____
- Stuttering---Comments: _____
- Intelligibility---Comments: _____
- Articulation---Comments: _____

RETURN THIS SCREENING FORM TO: _____

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